facilities made available for students to develop their own assignments through the Internet.

The programme delivers short periods of intense interactive study in the time and place of the learners choosing. The overall philosophy is to develop thinking skills rather than pure knowledge. It develops not only the traditional empirical arm of scientific thinking, but also the Hermeneutic or Interpretative side essential to the 'art' of general practice.[5] It is a programme run by practitioners, for practitioners.

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References

1. The Royal College of General Practitioners. Portfolio-based learning in general practice. Occasional Paper 63. London: RCGP, 1993.
2. The Royal College of General Practitioners. Higher professional education courses in the United Kingdom. Occasional Paper 51. London: RCGP, 1991.
3. The Royal College of General Practitioners. A college plan — priorities for the future. Occasional Paper 49. London: RCGP, 1990.
4. Smith Lindsay FP. Higher professional training in general practice: provision of master's degree courses in the United Kingdom in 1993. *BMJ* 1994; **308:** 1679-1682.
5. McWhinney I. *A textbook of family medicine.* Oxford: Oxford University Press, 1989.

Periconceptual folate supplementation

Sir,

Phull & Hirst (December *Journal,* p.688) highlighted some of the barriers to improving uptake of the recommendation for periconceptual folate supplementation.[1] The Medical Research Council concluded that folic acid taken periconceptually reduced the risk of recurrence of neural tube defects by 72%.[2] Recent data indicate that first occurrences can be reduced and other benefits have also been recorded.[3,4] Reducing the number of babies conceived with development abnormalities will improve both child and maternal health.

We developed an interest in the low uptake of this health policy and found a lack of research evidence in this area. Studies in secondary care suggest low levels of awareness,[5] but work planning interventions in primary care or assessing haematological values in the first trimester is lacking.

The Department of Health has commissioned the Health Education Authority to lead a campaign to increase periconceptual intake of folates and folic acid.[6]

The West Midlands NHS Executive R&D Programme are funding us to assess the impact of this national campaign. Women's awareness of the recommendation and their serum and red blood cell folate will be assessed at the outset of this campaign. We aim to study 1200 women in the first trimester of pregnancy with non-pregnant women of child bearing age as controls. The study will be repeated after the campaign to assess how awareness and haematological values have changed.

This research will provide baseline data in this important area of periconceptual care and also information about the impact of a national multi-media health promotion campaign.

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References

1. Department of Health. Folic acid and the prevention of neural tube defects. Report from an expert advisory panel. London: DoH, 1992.
2. MRC vitamin study research group. Prevention of neural tube defects: results of the Medical Research Council vitamin study. *Lancet* 1991; **346:** 393-396.
3. Shaw GM, Lammer EJ, Wasserman CR, O'Malley CD, Tolarova MM. Risks of orofacial clefts in children born to women using multivitamins containing folic acid periconceptually. *Lancet* 1995; **346:** 393-399.
4. Czeizel AE. Prevention of congenital abnormalities by periconceptual multivitamin supplementation. *BMJ* 1993; **306:** 1645-1648.
5. Clark NA, Fisk NM. Minimal compliance with the Department of Health recommendations for routine folate prophylaxis to prevent neural tube defects. *Br J Obstet Gynaecol* 1994; **101:** 709-710.
6. Hurren C, Elliott K. Prevention of first time occurrence of neural tube defects: campaign to increase periconceptual intake of folates and folic acid. London: Health Education Authority, 1995.

Crisis in recruitment

Sir,

Course organizers have been warning of a crisis in recruitment of general practice registrars for some time. Many reasons have been suggested for this decline in the popularity of general practice as a career but no firm opinions have been made. Course organizers in Yorkshire decided to ask fifth-year medical students of Leeds University and pre-registration house officers (PRHOs) in Yorkshire what influenced their choice of a career within medicine in order to use this information to promote general practice as a career option.

The study was carried out between August 1994 and February 1995. One hundred and ninety-two PRHOs and 103 fifth-year medical students returned the questionnaire, which asked for basic demographic data and whether the respondent had made a career choice, if general practice had been considered, and why or why not. Sixty-two per cent of PRHOs and 58% of students had made a career choice, the most popular speciality being general practice in both groups: 19% of PRHOs and 14.5% of students. Some 63.2% of PRHOs and 72% of students had considered general practice. Many had enjoyed their GP attachment in medical school, others saw it as a preference to the competitive world of hospital medicine. General practice was seen as offering variety, better hours and the ability to work in the community. The reasons for rejection included lack of intellectual stimulation, terrible hours and having to see a lot of non-ill patients.

A major factor in the choice of career appeared to be the enjoyment or otherwise of the GP attachment as a student, and the influence of other doctors during training. The suggestion that part of the pre-registration year should be spent in general practice is a positive step.[1] Many respondents complained of a lack of formal career advice.

There were few comments about political issues. Only one person mentioned the 24 commitment and one fundholding. The proposed introduction of summative assessment did not appear to be influencing this group.

While this study addresses the reasons for choosing or rejecting general practice, it does not answer the question as to why fewer doctors are choosing general practice now. The answers given could apply to the profession 5 years ago as to now. The future of general practice is bleak unless we can attract high-calibre recruits. More work needs to be done in this area.

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1. Harris CM. Pre-registration posts in general practice. *Medical Education* 1986; **20:** 136.

Aspirin in acute myocardial infarction

Sir,

We would endorse the statements by both Michael Moher (August *Journal,* p.444) and John Rawles (September *Journal,* p.504) about the importance of the involvement of the general practitioners in pre-admission aspirin treatment in acute myocardial infarction. Most studies have shown that few patients arriving at hospital with a suspected myocardial infarction have received aspirin,[1,2] despite the recognition by many authorities about the benefits of this.

In South Tyneside, the Medical Audit Advisory Group, in conjunction with the physicians, undertook a guidelines dissemination and implementation exercise involving general practitioners, doctors in accident and emergency and medical departments, doctors in deputising services, and ambulance paramedics, using a variety of strategies.[3]

The guideline stated that all patients diagnosed as having a suspected myocardial infarction should be given 300 mg of aspirin to chew and hold in their mouth as soon as was possible, unless there was a recognized contraindication. Of 164 patients that received aspirin as per the guideline, 43 were given it by their general practitioner, 31 by doctors in the accident and emergency department, five by ambulance paramedics, three self-administered and a further 82 were given it by a junior hospital physician. A further 123 did not receive 300 mg of aspirin. Whilst a proportion of these would have had the diagnosis of suspected myocardial infarction overturned when they were seen in hospital, and thus, not require aspirin, the majority should have received aspirin if they had been treated as per the guideline.

By making the provision of aspirin to patients suffering from a suspected acute myocardial infarction the responsibility of all clinicians involved in their care, we feel that a higher proportion receive this optimal care, and that despite arguments to the contrary,[4] we should continue to recommend that it should also be the responsibility of general practitioners and ambulance paramedics to give aspirin, and not just abdicate this responsibility to hospital doctors.

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References

1. Moher M, Johnson N. Use of aspirin by general practitioners in suspected myocardial infarction. *BMJ* 1994; **308:** 760.
2. Wylie HR, Dunn FG. Pre-hospital opiate and aspirin administration in patients with suspected myocardial infarction. *BMJ* 1994; **308:** 760-761.
3. Eccles MP. RCGP Guidelines Skills Course Material. London: RCGP, 1995.
4. Shetty BKK. Aspirin and suspected myocardial infarction [letter]. *BMJ* 1994; **308:** 1713-1714.

Register inaccuracy

Sir,

Harris and colleagues commented on list inflation, which was raised in our article (September *Journal,* p.463).

There are two separate but inter-related aspects to register inaccuracy. Most importantly, there are the clinical implications of inaccurate registers for screening, recall systems, morbidity recording and documentation of performance by primary care teams. Even in more affluent areas, inflation calculated by methods similar to our own was around 15%, and the interquartile range for our 16 (not three) practices was 21–27%. Deflation, where patients reside in a new area but delay in registering, is poorly researched, but is also likely to be a feature of deprived areas.

The administrators of both the cervical and breast screening programmes are well aware of register inaccuracy and have sought to define 'active patient denominators' using Prior Notification Lists. This has been successful for cervical screening, which receives active support by recruitment from the primary care team (resourced by target payments), and less successful for breast screening, where there are no additional resources for local recruitment programmes.

The principle of validation of registers/denominators needs to be incorporated into quality assurance programmes for clinical data, such as preventive care, disease registers and associated variables, if meaningful comparisons are to be made between practices and areas, and registers of real people are to be clinically useful.

In our subsequent 1994 audit, we stopped writing to patients for validation purposes as it was too complex for routine use. We have also found that computer usage has been considerably more rapid than we thought and future audits/registers will be based on computer searches (though reference to paper records may need to be made as part of quality assurance). Some simple method of validation is still required and a consensus on this remains to be established. In the meantime, unexpurgated registers will continue to underestimate performance and need, particularly in areas of deprivation and high turnover.

Payment based on capitation is a related but separate issue. Harris and colleagues are quite right, this is unlikely to be addressed through the 'back door' of clinical registers and preventive activity. It is more effectively addressed through administrative improvements such as GP-links. This is a model of good practice and democracy of data handling!

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Chlamydial infection in women

Sir,

In their editorial on management of chlamydial infection in women (November *Journal,* p.615), Pippa Oakeshott and Phillip Hay state that the failure rate of erythromycin treatment is 37%. The source of this figure was not clear, but I believe that it originates from a Canadian study in which 35 male patients with urethral chlamydia infection were treated with low-dose erythromycin, namely 250 mg qds for 7 days.[1] Historically, many studies of erythromycin therapy for genital chlamydial infection have suffered from inadequate dosage or patient numbers; indeed, one frequently cited study included a series of only five women.[2]